

Utah Medicaid Provider Manual	Speech-Language Services
Division of Health Care Financing	Updated January 2004

SECTION 2

SPEECH - LANGUAGE SERVICES

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1 SPEECH-LANGUAGE SERVICES

Speech-language services are covered services of the Utah Medicaid Program.

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1 - 1 Credentials

A speech-language pathologist must hold a current professional license in the State of Utah, may provide services only in that licensed specialty, and may supervise according to State Licensing Law.

1 - 2 Billing

Speech services are billed either through the electronic data exchange or on a HCFA-1500 claim form, using the procedure codes listed in Chapter 5. Refer to billing instructions in SECTION 1, Chapter 11 - 9, Billing Medicaid. Internet address: <http://www.health.state.ut.us/medicaid/pdfs/SECTION1.pdf>

The speech-language pathologist must provide and bill only for services which were medically indicated and necessary for the recipient, were personally rendered by the provider, or were rendered by a supervised individual (under State Licensing guidelines) with immediate personal supervision of a licensed speech-language pathologist. Immediate personal supervision means the critical observation, physical presence, and guidance of speech-language pathology services by a licensed speech-language pathologist.

Each service billed to the Medicaid Program must be documented in the recipient's file and be available to Medicaid auditors, monitors, and/or surveyors.

1 - 3 Definitions

Speech-language Pathologist: A person specifically trained and licensed to perform the functions described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41, including those specifically exempted as set forth under 58-41-4(1).

Speech-language Pathology Aide: A person who meets the minimum qualifications established by the board for speech-language pathology aides, does not act independently, and works under the personal direction and direct supervision of a licensed speech-language pathologist who accepts the responsibility for the acts and performances of that speech-language pathology aide.

Treatment: The services of a speech-language pathologist to examine, diagnose, correct or ameliorate speech-language disorders, abnormalities, behavior or their effects.

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2 COVERED SERVICES

- A. Speech-language services, for individuals and/or groups of individuals with speech and language disorders, include evaluative, diagnostic, screening, preventive or corrective processes planned and provided by a speech-language pathologist for which a recipient is referred by a physician. (See 42 CFR 440.110 (c)).

Services include examination, diagnosis, and treatment of the speech/communication disabilities and related factors of individuals with certain voice, speech, hearing and language disorders. These services treat problems associated with accident, illness, birth defect, or injury. Nonorganic or organically based speech-language articulatory deviations, voice disorders, language impairments, or disfluencies may be included in the treatment plan in some specific instances. See Chapter 2 - 2, Limitations.

Services provided to recipients when they are hospitalized (inpatient) are not reimbursable independently. They are part of the hospital DRG payment.

1. A written plan of care established by the speech-language pathologist is required. The plan of care should include:
 - a. Patient information and history;
 - b. Current medical findings;
 - c. Diagnosis;
 - d. Previous treatment;
 - e. Anticipated goals;
 - f. Anticipated treatment; and
 - g. The type, amount, frequency and duration of the services to be rendered.
2. The total medical care of each patient is under the direction of a physician. The speech pathologist must review the plan of care and results of treatment of each Medicaid patient in need of speech-language pathology services as often as the patient's condition requires (See 42 CFR 405.1717(b)).
3. The therapist IS responsible to discontinue indefinite treatment without physician's consultation.
4. Medicaid policy allows:
 - a. Diagnostic treatment for purposes of evaluation in instances where definitive examinations and tests are not possible to administer, because of the condition of the recipient;
 - b. Short-term treatment, where it is expected that goals and objectives for a particular recipient would be met in 12 or fewer sessions;
 - c. No delay in initiating treatment, where an evaluation indicates the need for immediate service.

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B. Speech Therapy for Cognitive Therapy

Prior authorization is required for cognitive therapy. Criteria for approval are as follows:

1. Diagnosis of :
 - a. CVA. Treatment must begin within 90 days of the incident, OR
 - b. Traumatic Brain Injury. Treatment must begin within 18 months of the injury.
2. Speech therapy for cognitive purposes must be ordered by a physician and must include a plan of care. Speech therapy for cognitive disorders should typically begin after speech therapy for dysphagia and motor function speech issues have been addressed. The care giver, if possible, must attend the therapy sessions to receive instructions to work with the recipient and reinforce therapy and conduct repetitions with the patient.
3. Therapy is limited to 12 visits over 60 days and one per month for the next three months for a maximum total of 15 visits.

Bill for cognitive therapy using code 92507.

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2 - 1 Evaluation

An evaluation may be provided once per 12-month period. Evaluations include intake, history, evaluative measures (tests), scoring, and report writing.

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The time involved and billed for must be well documented. Tests are included in the evaluation and may not be billed separately.

All speech-language pathology services must be referred or recommended by a physician who is responsible for the overall medical direction of such services as part of the total care of the patient, and who maintains a written plan of care or patient summary. The specific tests used in the evaluation do not need to be referred or identified by the physician.

See Chapter 5 for a list of approved procedure codes.

2 - 2 Limitations

Services for abnormal pitch, quality, tone, fluency or rhythm are not Medicaid benefits, except when due to accident, illness, birth defect, or injury.

2 - 3 Dysphagia Services

Services specifically related to the treatment of dysphagia are covered and require Prior Authorization. Medicaid will reimburse for an evaluation for dysphagia therapy, therapy sessions, and training in techniques for dysphagia therapy.

2 - 4 Electrolarynx

An electrolarynx (artificial larynx) is a covered benefit for Medicaid clients. The device may be provided by a Medicaid provider of medical supplies and equipment. An electrolarynx is considered a prosthesis and is covered for Medicaid recipients who have permanently lost their voice due to laryngectomy, illness, injury or paralysis.

Written prior authorization is required and should be submitted, along with supporting documentation by the provider of the device.

In addition, a speech-language pathologist may provide necessary training for utilization of the device. The regular speech therapy codes should be used. Please follow the usual process for obtaining prior approval for the therapy sessions.

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2 - 5 Speech Augmentative Communication Devices

Utah Medicaid will authorize Speech Augmentative and Alternative Communication Devices as speech language therapy services when medical necessity criteria as defined in this document are met. Medicaid reserves the right to provide partial funding for the device when the client also has significant educational and developmental needs. Medicaid funding is authorized only for the portion of the cost of the device needed for medical necessity. In such circumstances coordination and negotiation will occur with other appropriate funding sources. Local interagency agreements will be implemented to determine funding sources for a Speech Augmentative Communication device.

A. Definitions

1. "Augmentative and Alternative Communication Devices" means electronic or non-electronic aids, devices, or systems that correct expressive communication disability. All such devices will be referred to as Speech Augmentative Communication Device (SACD). The device is a prosthesis to replace a non-functioning, damaged, or absent body part.
2. "Augmentative and Alternative Communication Accessories" means device related components and accessories, necessary supplies.
 - a. Medical necessity must be documented for the specific accessory(ies) requested.
 - b. SACD Accessories primarily for educational or social needs are not a benefit of the Medicaid program.
3. "Medical Necessity" is a service or supply that is (1) reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endangers life, causes suffering or pain, causes physical deformity or malfunction, or threatens to cause a handicap; and (2) there is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly. Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality(R414-1-2(17)).
4. "SACD Assessment" means an assessment, provided in a written format acceptable to the Division accompanying a request for prior authorization of SACD devices and/or services. The Assessment shall be conducted by a Utah licensed speech language pathologist and may be in conjunction with other appropriate licensed practitioners of the healing arts acting within their scope of practice, including physical and occupational therapists, if the client has physical limitations which may impact his/her ability to use the SACD device.
5. "SACD Speech Therapy Training" means up to eight speech therapy visits within any contiguous twelve-week period, when authorized in conjunction with prior authorization of a SACD device.
6. "Prosthetic Devices" are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law to:
 - a. Artificially replace a missing portion of the body;
 - b. Prevent or correct physical deformity or malfunction; or
 - c. Support an absent or deformed portion of the body.

[See 42 CFR § 440.120(c), Definitions of Prosthesis.]

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B. General Criteria

A SADC device is provided as a Medicaid benefit by prior authorization when all of the following conditions are met:

1. The client must meet the requirements of 42 CFR § 440.120(c) as determined by the Division's professional health care staff.
2. The device is medically necessary following surgery, accident, disease or a birth defect which results in damage to the speech controlling mechanisms.
3. The SADC is a prosthesis to replace a non-functioning, damaged or absent speech controlling mechanism.
4. The prognosis must indicate the condition(s) for which this type of device is requested. Documentation must be submitted indicating the condition is stable or can be improved with the device. If the condition will rapidly deteriorate within a six-month period affecting the effective use of the device, it will not be approved. If the condition is temporary and the client's ability to communicate will improve with further treatment within a six-month period, the device will not be approved (e.g. surgical correction).
5. The client must have the mental and physical capacity to appropriately use the device to communicate medical or basic functional needs in his usual communication environment(s).
6. The client must be unable to adequately communicate medical or basic functional needs in order to qualify for the device to be funded by Medicaid. Requests for funding when the primary need is social or educational should be submitted to other appropriate funding sources.

C. Prior Authorization

1. Written documentation of all of the following additional specific criteria must be submitted:
 - a. The client's medical diagnoses and significant medical history including:
 - (1) previous treatment(s) of damaged, malfunctioning, or absent speech controlling mechanisms;
 - (2) visual, hearing, tactile and receptive communication impairments or disabilities including prognosis, and the impact on the client's expressive communication, including speech and language skills and prognosis with and without the device;
 - (3) current communication abilities, behaviors and skills, and the limitations interfering with meaningful communication of medical and basic functional needs in current and projected daily activities;
 - (4) motor status, optimal positioning and access methods and options, if any, for integration of mobility with the SCAD;
 - (5) current communication needs, and projected communication needs within the next two years;
 - (6) communication environments, and constraints which impact SADC device selection and features.

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- b. The assessment shall also include a summary of the SACD proposed for the client which describes:
 - (1) vocabulary requirements;
 - (2) representational systems;
 - (3) display organization and features;
 - (4) rate enhancement techniques;
 - (5) message characteristics, speech synthesis, printed output, display characteristics, feedback auditory and visual output;
 - (6) access techniques and strategies;
 - (7) portability and durability;
 - (8) type and significant characteristics and features of the SACD;
 - (9) cost;
 - (10) any trial period when the client used the recommended device in an appropriate home and community-based setting.
 - (11) documented evidence the client is able and willing to use the device effectively;
 - (12) why the requested SACD and services are the most effective and least costly alternative available to treat the client's communication limitations;
 - (13) whether rental or purchase of the SACD device is the most cost effective option and why;
 - (14) vendors;
 - (15) warranty and service provisions available for the SACD device(s) and services, if any.
 - (16) SACD reimbursement is manually priced by Medicaid reviewers at 75% of the manufacturer's published price, not to exceed 85% of the Medicare allowable for Utah which is \$5724.00 as of 10/01/02.
2. The Prior Authorization request shall also include a Treatment Plan, stating the following:
 - a. the expected duration of need for the device, and the amount, duration and scope of any related services requested, how the device will enable the client to effectively meet his/her medical and basic functional communication needs;
 - b. short-term communication goals;
 - c. long-term communication goals;
 - d. criteria to be used to measure the client's progress towards meeting both short-term and long-term goals;
 - e. which service providers will be used and their expertise and experience in rendering services.
3. The Prior Authorization request shall also include Professional Orders and assessments.
 - a. A written order from a licensed physician documenting the device is medically necessary to correct an expressive communication disability.
 - b. A written assessment completed by a Utah licensed speech language pathologist. The assessment may be in conjunction with other licensed practitioners of the healing arts acting within their scope of practice, including physical and occupational therapists, if the client has physical limitations which may impact his/her ability to use the SACD.

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D. Modifications, Replacement, Service or Repairs

All modifications, replacement, service or repairs require prior authorization.

1. Request for SACD device modifications or replacements

Prior authorization is required for any modification or replacement of an SACD or services. Such requests must be accompanied by a new SACD Assessment and Treatment Plan. Written documentation verifying significant change has occurred in the client's expressive communication abilities or limitations is required.

2. SACD device repair

Prior authorization is required for each request for repair of SACD and/or services. The reason or justification for the repair service including the total cost of parts and labor must be submitted in writing.

E. Medicaid Codes

E2502 Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time

E2508 Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device.

E2510 Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access.

E2512 Accessory for speech generating device, mounting system

92607 Evaluation for Speech-Generation and Alternate Communication device, 1 hour

92609 Therapy services for use of Speech-Generation device

92608 Evaluation for Speech-Generation and Alternate Communication device, additional 30 minutes

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3 PRIOR AUTHORIZATION

All therapy sessions require prior authorization.

Before any therapy services are provided, the therapist should request prior authorization which includes a plan of treatment for the patient or a document outlining the following:

1. Diagnosis and severity of the condition;
2. Prognosis for progress;
3. Objectives of the specific treatment;
4. Detail of the method(s) of treatment;
5. Frequency and length of treatment sessions and duration of the program.

The maximum treatment period for which prior authorization will be given is six months.

Requests for extended service will be evaluated by Medicaid consultants on a case-by-case basis. Unless a unique situation exists, no reauthorization will be approved.

The clinician's new plan of treatment must be submitted with the prior authorization request. A medical evaluation from both the clinician and a physician must also be attached. (Refer to consultation code.) Please include any supplemental data such as post-treatment progress made, family problems that may hinder progress, and a definite termination date.

Mail all Prior Authorization requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 142904
SALT LAKE CITY UT 84114-2904

Fax Number

Prior authorization requests may be faxed to:
(1-801) 538-6382, attention "Prior Authorizations."

For more information about prior authorization procedures, please refer to SECTION 1 of this Provider Manual, Chapter 9, Prior Authorization Process.

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3 - 1 Requests for Retroactive Authorization

Requests for retroactive authorization will be approved only under three conditions:

1. A different therapist is involved, or
2. Medicaid was responsible for the delay (in either case Medicaid will only backdate to the day the request was received), or
3. The patient is made eligible for Medicaid retroactively, and services follow Medicaid guidelines.

This retroactive eligibility may be given within a maximum of 90 days from date of service

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4 NON-COVERED SERVICES

The following services are not Medicaid benefits at this time:

1. Treatment for social, educational, or developmental needs.
2. Treatment for recipients who have stable, chronic conditions which cannot benefit from communication services.
3. Treatment for recipients with no documented evidence of capability or measurable improvement,
4. Treatment for recipients who have reached maximum potential for improvement.
5. Treatment for recipients who have achieved stated goals.
6. Treatment for non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board.
7. Treatment for children who are slow to speak but have no medical problem.
8. Treatment for disfluencies such as stuttering or stammering or rhythm abnormalities which are not related to accident, illness, birth defect, or injury.
9. Treatment for articulation problems, such as "lisp" or the inability to provide certain consonants, which are not related to accident, illness, birth defect or injury.
10. Treatment for voice anomalies such as pitch, tone, quality, or rhythm, except when due to accident, illness, birth defect, or injury.
11. Treatment for CVA which begins more than six months after onset.
12. Treatment for residents of an ICF/MR (this is included in the per diem resident rate).

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5 PROCEDURE CODES

The table which follows describes speech - language services covered by Medicaid and conditions of coverage. However, this list does NOT apply to services to be provided to a Medicaid client **who is enrolled in a capitated managed care plan**, such as a health maintenance organization (HMO). Medicaid clients who are enrolled in an HMO receive speech - language services as a benefit of the plan. The plan specifies which services, if any, require authorization and conditions for authorization. The client's Medicaid Identification Card states the name of any plan(s) in which the client is enrolled. Refer to SECTION I of this Provider Manual, Chapter 4, Managed Care Plans, for more information.

Medicaid does NOT process prior authorization (PA) requests for services covered under contract with a managed care plan. Providers requesting PA for services to a client enrolled in a managed care plan will be referred to that plan. Medicaid processes PA requests ONLY for services which are not covered by a managed care plan and which may be covered directly by Medicaid.

The list of procedure codes covered by Medicaid is updated by Medicaid Information Bulletins until republished in its entirety. An explanation of individual items on the tables follows:

Code The code is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid.

P A "P A" is prior authorization required by the Division of Health Care Financing prior to services being rendered. When a code requires Prior Authorization, the procedure must be authorized by Medicaid BEFORE the service is given. "W" means a written prior authorization is required. Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 142904
SALT LAKE CITY, UTAH 84116-2904

or use FAX NUMBER : (801) 538-6382

Criteria The criteria listed are required by Medicaid before the item will be reimbursed and include criteria used by Medicaid staff to review a request for prior authorization.

Limits Indicates the allowable number of times the item may be reimbursed and other pertinent information.

KEY TO DISTINGUISHING CODE CHANGES

New codes are in bold print.

A vertical line in the margin, like the example to the left, marks where text was changed or added.

An asterisk (*) marks where a code was deleted.

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CODE	DESCRIPTION	P A	CRITERIA - COMMENTS	LIMITS
92506	Evaluation fo speech, language, voice communication, auditory processing, and/or aural rehabilitation status		Documentation for time involved must be present in patient's chart. Also includes plan of care, goals, objectives, number of treatments recommended and termination.	One time only at onset of service following referral.
L8507	Tracheo-esophageal voice prosthesis, inserted by patient	W	Permanent loss of voice from laryngectomy, illness, injury or paralysis.	1 per year
L8509	Tracheo-esophageal voice prosthesis, inserted by provider	W	Permanent loss of voice from laryngectomy, illness, injury or paralysis.	1 per year
92507	Treatment of speech, language, voice communication, and/or auditory processing disorder (includes aural rehabilitation); individual.	W		
92508	Treatment of speech, language, voice communication, and/or auditory processing disorder (includes aural rehabilitation); group	W	Documentation for time involved must be present in patient's chart. Also includes plan of care, goals, objectives, number of treatments recommended and termination.	One time only at onset of service following referral.
92610	Evaluation of oral & pharyngeal swallowing function.	W	Authorization is based on the medical needs of the individual patient	
92510	Aural rehabilitation following cochlear implant (includes eval of aural rehab status and hearing therapeutic services) with or without processor programming	W	Authorization is based on approval for cochlear implant	
K0544	SACD	W		
K0546	SACD Mount	W		
K0547	SACD Accessories	W		
V5336	Repair/modification of augmentative communication device			Submit itemized invoice. Includes time, handling, and parts.
92607	Evaluation for Speech-Generation and Alternate Communication device, 1 hour			
92608	Evaluation for Speech-Generation and Alternate Communication device, additional 30 minutes			
92609	Therapy services for use of Speech-Generation device	W		

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